Connecticut SIM Logic Model: Legend

Categories

- 1. Inputs: A set of defined resources that will enable the activities to be accomplished
- 2. Activities: Defined set of activities conducted to address the health care issues
- 3. Outputs: Evidence produced from the completed activities
- 4. Outcomes: Defined measures/changes that will occur within the four year grant from the completed activities
- 5. Impacts: Overall, statewide changes that will occur as a result of completing the activities

Terminology

Initiatives

- 1. AMH: Advanced Medical Home
- 2. CCIP: Community and Clinical Integration Program
- 3. MQISSP: Medicaid Quality Improvement and Shared Savings Program
- 4. VBID: Value-Based Insurance Design
- 5. VBP: Value-Based Payment

Other

- 1. AN: Advanced Networks
- 2. BH: Behavioral Health
- 3. CCT: Comprehensive Care Team
- 4. CHW: Community Health Worker
- 5. FQHCs: Federally Qualified Health Centers
- 6. HEC: Health Enhancement Community
- 7. MH: Medical Home
- 8. PSC: Prevention Service Center
- 9. TA: Technical Assistance

Connecticut SIM Logic Model: Detailed Information (1/4)

a.4 MOU w/behavioral health provider (guidelines on information sharing; tech. to alert PCP referral

a.6 Protocol and tech solutions to make assessment and care plan available to PC team with consent

a.5 Ongoing training for PCP around BH (promotion, detection, diagnosis, referral)

Outcomes/Impact Inputs **Activities** Outputs _____ **Improve Health Care Quality** Process/ Structural Outcomes A.1 MQISSP: 400,000+ lives by 2019 • 88% of Medicaid beneficiaries in VBP by 2020 Value-based Payment (VBP) A.2 All payers aligned on core quality measures used in VBP • Commercial payers xx% of members in VBP by 1. Increase adoption of value-based payment through payer and provider engagement and MQISSP a. preventative services: Breast Cancer, Cervical Cancer, and Colorectal 2. Align all payers around core quality measures for use in value-based payment contracts that reward Cancer Screening, Well Child Visits in first 15 months of life, Adolescent • **SIM Grant Funds** 88% of CT population goes to PCP responsible for improvement in: well care visits, Wgt. assessment and counseling for nutrition and the quality and cost of their care by 2020 a. preventative services (cancer screening, mammograms, well-child visits) physical activity for children/adolescents Multi Stakeholder chronic care services (diabetes, asthma, hypertension) b. chronic care services: Medication management for people w/ asthma, Workgroups: HISC, Quality of Care Impact c. <u>behavioral health services</u> (depression screening, depression remission, ADHD management); Asthma Medication Ratio, DM: Hemoglobin A1c Poor Control (>9%), PTTF, QC, EAC, HIT, • Increase in colorectal screening for adults 50+ d. effective management of individuals with complex care needs (ED use, readmissions) DM: HbA1c Testing, DM: Diabetes eye exam, DM: medical attention for PHC, MAPOC, from 75.7% to 83.6%; Increase in colorectal 3. Deploy health information technology solution that can support the extraction of clinical data to allow nephropathy, Controlling high blood pressure screening for low income adults from 64.9% to **Employer** payer adoption of clinical measures for value-based payment c. behavioral health services: Follow-up care for children prescribed ADHD 68.2% Consortium, Rapid medication, Metabolic Monitoring for Children and Adolescents on • Increase in mammograms for women ages 50+ Response Team, Antipsychotics, Depression Remission at 12 Twelve Months, Child & Consumer Advisory in last two years from 83.9% to 87.7% Adolescent Major Depressive Disorder: Suicide Risk Assessment, Board • Increase optimal diabetes care – as measured by Unhealthy Alcohol Use – Screening 2+ annual A1c tests from 72.9% to 80.1%; d. effective management: Plan all-cause readmission, ED usage per 1,000 Stakeholder Increase in adults with hypertension who take A.3 Payers accurately collect clinical data from provider EHRs in automated way hypertension medication from 60.1% to 69.5% **Engagement:** Reduction in **ED use** with asthma as the primary Employers, Community and Clinical Integration Program (CCIP) Consumers, diagnosis from 73 to 64 per 10,000 Provide TA/awards to MQISSIP participants to achieve standards in comprehensive care management, · Reduction in number of mental health days Providers, Health including: Reduction of risk-standardized all-condition plans, Government B.1 30 ANs/FQHCs succeed in CCIP standards by 2019 demonstrating improved a.1 Networks having the capability to identify complex patients through risk stratification that considers readmissions from 15.9% to 13.1% management of individuals with complex health needs and have analytic clinical, behavioral, and social risk factors **Regulatory Levers** Reduction in ambulatory care sensitive tools to better predict who requires care management a.2 Process for connecting patients to a comprehensive care team (CCT) (w/ Community Health Worker) condition admissions to 1,449 to 1,195 per a.1-3 Providers can identify complex individuals who will benefit from the to receive more intensive care management support (Work flow still needed to be defined, may need HIT: Direct 100.000 support of a CCT technology solution) · Increase in adults who have a regular source of messaging, b.1-2 Ability to understand the historical and current clinical and social a.3 CHW performing care coordination and linking individuals with social service Provider Directory, care from 83.9% to 93.0% needs of individuals b.1 Root cause analysis and a person-centered needs assessment to identify and implement additional ADT, edge server, Increase in children well child visits for at-risk Providers receive timely alerts for hospital related care events even interventions eMPI, consent pop. from 62.8% to 69.1% when the hospital is not in network b.2 Developing person-centered care coordination plan registry, disease • Decrease in premature death rates for adults Providers have efficient process for managing consent, easing Modifying process for exchanging health info. across care settings to accommodate function of CCT due to cardiovascular disease to 889 to 540 per registries communication with care partners, efficient & effective health On-going monitoring of patient condition 100,000 information sharing across the health neighborhood Evaluating the model: tracking aggregate measures; method to share performance data with CCT Patients have a better care experience, feel more engaged, and 2. Provide TA/awards to MQISSIP participating entities to achieve standards in behavioral health integration, better adhere to treatment which is tuned to values, preferences, and Health Care Sustainably Impact Consumer including: • Achieve a rate of healthcare expenditure **Engagement:** goals a.1 Providers having capability to utilize screening tool for mental health, substance abuse, and trauma Focus groups, growth no greater than the increase in gross Providers use disease registries and evidence based decision support needs (in PC setting) listening sessions, state product (GSP) per capita, corresponding to address gaps in care a.2 Assessment of needed behavioral health resources and mechanism for identifying resources forums to a 1-2% reduction in the annual rate of B.2 30 ANs/FQHCs demonstrate improved identification of BH conditions a. 3 Collaborating with BH providers and patient through mutual agreement and develop processes and with effective treatment, referral and/or follow-up healthcare growth. protocols (referral tracking, follow-up, etc.)

a.1-6 Providers have improved ability to identify and treat BH needs

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Connecticut SIM Logic Model: Detailed Information (2/4)

Outcomes/Impact Inputs **Activities** Outputs _____ **Improve Health Care Quality** Advanced Medical Home (AMH) 1. Provide TA to non-MH practices in MQISSIP participating Advanced Networks to achieve standards in Process/ Structural Outcomes C.1 Care is more person-centered, team-based, preventative, evidence-based, Patient-Centered Access, Team-based Care, Population Health Management (e.g., Mental health/ 300+ practices are AMH by 2019 population health oriented, coordinated, and effective **SIM Grant Funds** substance use history of patient and family, standardized tool for developmental screening), Care • 87% of insured population in VBID by 2020 C.1 Improved practice and patient experience Management and Support, Care Coordination and Care Transitions (e.g., proactively identifying patients C.2 Pilot sites receive NCQA Level 2 or Level 3 Patient-Centered Medical Home Multi Stakeholder with unplanned hospital admissions and emergency department visits), Performance Measurement and Quality of Care Impact recognition Workgroups: HISC, 2 • Increase in colorectal screening for adults 50+ C.3 Participating PCPs meet the required criteria to fulfil Planetree Bronze PTTF, QC, EAC, HIT, Pilot program (AMH Vanguard) with 50 practices who receive state funded practice transformation from 75.7% to 83.6%; Increase in colorectal Recognition for Achievement in Patient-Centered Care PHC, MAPOC, support for up to 15 months screening for low income adults from 64.9% C.4 PCPs move toward person-centered care through changes in leadership **Employer** to 68.2% 3. Provide support to non-MH practices to achieve Planetree Patient-Centered Bronze Recognition for approach, culture and systems and maximizing the sharing among Consortium, Rapid excellence in patient-centered care • Increase in mammograms for women ages practices of resources, tools, and strategies for practice transformation. Response Team, 50+ in last two years from 83.9% to 87.7% 4. Participants take part in Learning Collaborative conducted by Qualdigm consisting of in-person meetings, Consumer Advisory virtual group education meetings, and technical assistance · Increase optimal diabetes care - as measured Board by 2+ annual A1c tests from 72.9% to 80.1%; Increase in adults with **hypertension** who Value-based Insurance Design (VBID) Stakeholder take hypertension medication from 60.1% to Engage employers to adopt VBID health plans that reward use of disease management & treatment **Engagement:** D.1 Employers adopt value based insurance designs 69.5% support services, high performing providers who adhere to evidence-based treatment, high value Employers, D.1 Consumers empowered to make healthier lifestyle decisions and engage Reduction in **ED use** with asthma as the treatment services Consumers, in illness self-management primary diagnosis from 73 to 64 per 10,000 Providers, Health Reduction in number of mental health days plans, Government Reduction of risk-standardized all-condition readmissions from 15.9% to 13.1% **Regulatory Levers** • Reduction in ambulatory care sensitive condition admissions to 1,449 to 1,195 per HIT: Direct 100.000 messaging, Increase in adults who have a regular source Provider Directory, of care from 83.9% to 93.0% ADT, edge server, Increase in children well child visits for at-risk eMPI, consent pop. from 62.8% to 69.1% registry, disease • Decrease in premature death rates for adults registries due to cardiovascular disease to 889 to 540 per 100,000 Consumer **Engagement:** Health Care Sustainably Impact Focus groups, • Achieve a rate of healthcare expenditure listening sessions, growth no greater than the increase in gross forums state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.

Connecticut SIM Logic Model: Detailed Information (3/4)

Inputs	Activities	Outputs ———	Outcomes/Impact
SIM Grant Funds Multi Stakeholder Workgroups: HISC, PTTF, QC, EAC, HIT, PHC, MAPOC,	 Reduce Health Disparities Value-based Payment (VBP) Align all payers around core quality measure set that reward improvement in health equity: a. chronic care (diabetes, asthma, hypertension) b. effective management of individuals with complex care needs (ED use, readmissions) 	 A.1 Alignment across all payers on core quality measures focused on health equity improvement a. <u>chronic care</u>: Medication management for people w/ asthma, Asthma Medication Ratio, DM: Hemoglobin A1c Poor Control (>9%), DM: HbA1c Testing, DM: Diabetes eye exam, DM: medical attention for nephropathy, Controlling high blood pressure b. <u>effective management</u>: <u>effective management</u>: Plan all-cause readmission, ED usage per 1,000 	Process/ Structural Outcomes • 88% of CT population goes to PCP responsible for the quality and cost of their care by 2020 • 300+ practices are AMH by 2019 Quality of Care Impact Improved core dashboard measures for equity gaps in target selected areas: > Diabetes: Reduce disparities in rates of A10 Poor Control > Asthma: Reduce disparities in asthma medication ratio > Hypertension: Reduce disparities in controlling blood pressure > Consumer Experience: Reduce disparities in consumer experience survey results
Employer Consortium, Rapid Response Team, Consumer Advisory Board	B. Community and Clinical Integration Program (CCIP) 1. Provide TA/awards to MQISSIP participating entities to achieve standards in health equity improvement, including: a.1 Networks have the capability to analyze select clinical performance and care experience measures stratified by race/ethnicity, language, etc. a.2 Networks have tool to conduct risk stratification that takes into consideration utilization, health outcomes and social determinants of health a.3 Networks have tool to track aggregate clinical outcome and care experience measures aligned with disparity measures a.4 Networks have tool to identify valid clinical and care experience measures to compare performance between sub populations b. Designing one culturally & linguistically appropriate chronic illness to address gaps, which incorporates a CHW c. Developing processes and protocols for connecting individuals to needed community services	 B.1 30 ANs/FQHCs succeed in CCIP standards by 2018 demonstrating standardized processes in health equity improvement and have analytic tools to better compare different populations a.1-4 Networks will be able to identify disparities in care on a routine basis, prioritize the opportunities for reducing the identified disparities, design and implement interventions, scale those interventions across networks, and evaluate the effectiveness of the intervention a.1-4 Reduction in health equity gaps through standardizing certain elements of the care processes to be more culturally and linguistically appropriate b. Health systems integrate CHWs c. Efficient & effective health information sharing across the health neighborhood exists 	
HIT: Direct messaging, Provider Directory, ADT, edge server, eMPI, consent registry, disease registries	 Advanced Medical Home (AMH) Provide TA to non-MH practices in MQISSIP participating Advanced Networks to achieve standards in cultural &linguistic appropriate services, assessment of health literacy, health equity oriented quality improvement 	C.1 Care is more centered on achieve best-practice standards in health equity improvement	Health Care Sustainably Impact Achieve a rate of healthcare expenditure growth no greater than the increase in gross state product (GSP) per capita, corresponding to a 1-2% reduction in the annual rate of healthcare growth.
Consumer Engagement: Focus groups, listening sessions, forums			

Connecticut SIM Logic Model: Detailed Information (4/4)

Activities

Inputs

Improve Population Health A.1 All payers aligned on core quality measures used in VBP A. Value-based Payment (VBP) a. preventative services: Breast Cancer, Cervical Cancer Screening, 1. Align all payers around core quality measure set that rewards improvement in: **Process/ Structural Outcomes** Colorectal Cancer Screening, Well Child Visits in first 15 months of life, a. preventive care processes (tobacco cessation, weight assessment and counseling, cancer screening, Adolescent Well care visits, Wgt. assessment and counseling for nutrition • 88% of Medicaid beneficiaries in VBP by 2020 **SIM Grant Funds** well visits) and physical activity for children/adolescents Commercial payers xx% of members in VBP 2. Establish and implement reliable & valid measures of community health improvement by 2020 A.2 Improved population health in areas in areas of focus Multi Stakeholder Deploy health information technology solution that can support the extraction of clinical data to allow 88% of CT population goes to PCP responsible A.3 Payers accurately collect clinical data from provider EHRs in automated Workgroups: HISC, payer adoption of clinically-based measures for value-based payment PTTF, QC, EAC, HIT, for the quality and cost of their care by 2020 way 300+ practices are AMH by 2019 PHC, MAPOC, Advanced Medical Home (AMH) 87% of insured population in VBID by 2020 **Employer** 1. Provide TA to non-MH practices in MQISSIP participating Advanced Networks to achieve standards related Care is more centered on achieving best-practice standards in population 2-3 PSCs offering evidence-based community Consortium, Rapid to population health management health management preventive services in affiliation with Response Team, providers exist in the state by Q1 2018 Consumer Advisory Population Health Plan Design and Implementation • 1-2 HECs exist in the state by Q1 2019 Board Designate Prevention Service Centers (PSC) to strengthen community-based health services C.1 2-3 PSCs offering evidence-based community preventive services are Design and designate (HECs) to target resources and facilitate coordination and collaboration among designated Population Health Measures Impact Stakeholder multiple sectors, including relationships among ACOs and community stakeholders • Reduction in percent of **obese** adults from C.2 1-2 HECs are designed and designated **Engagement:** 3. Conduct root cause and barrier analysis for tobacco, obesity, diabetes & identify evidence-based 24.5% to 22.95% and percent of obese C.3 Networks have ability to understand the historical and current clinical and Employers, interventions children from 18.8% to 17.65% social needs of individuals for preventative services Consumers, 4. Engage health, government, and community stakeholders C.4 Early buy-in, successful program design, and establishment of long-term Reduction in percent of obese children in low Providers, Health 5. Establish and implement reliable & valid measures of community health improvement income households from 38% to 35.55% plans, Government 6. Develop financial incentive model to reward health enhancement communities for health improvement · Reduction in percent of adults who smoke to C.5 Communities track and are accountable for community health measures 14.40% and youth who smoke from 14% to (Date TBD) **Regulatory Levers** 12.72% C.6 Comprehensive financial model for HEC developed by Q2 2017 • Reduction in percent of low income adults HIT: Direct who smoke from 25% to 22.43% messaging, Value-based Insurance Design (VBID) Reduction in adult diabetes to 7.86% Provider Directory, D.1 Employers adopt value based insurance designs 1. Engage employers to adopt VBID health plans that reward healthy lifestyles (e.g., physical activity) targeted Reduction in low income adults with diabetes ADT, edge server, D.1 Consumers empowered to make healthier lifestyle decisions and engage towards reducing rates of diabetes, obesity, tobacco use, hypertension, etc. and use of high value from 14.3% to 11.32% eMPI, consent in illness self-management preventative services registry, disease **Health Care Sustainably Impact** registries • Achieve a rate of healthcare expenditure growth no greater than the increase in gross Cost Goals PMPM Baseline 2020 Goal state product (GSP) per capita, Consumer corresponding to a 1-2% reduction in the **Engagement:** ASO/Fully Insured \$457 \$603 annual rate of healthcare growth. Focus groups, State employees w/o Medicare \$547 \$722 listening sessions, forums Medicare \$850 \$1,096 Medicaid/CHIP, incl. expansion \$390 \$509 Average \$515 \$679

Outcomes/Impact

Outputs _____